AMENDED IN SENATE JUNE 14, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 1749

Introduced by Committee on Health (Dymally (Chair), Bass, Berg, De Leon, Gaines, Hancock, Hayashi, Huff, Jones, Lieber, and Salas)

March 22, 2007

An act to amend Sections 1341.4, 1342.5, 1343, 1347.15, ~~and 1352~~ *1352, 1367.07, and 1389.4* of, and to repeal Section 1342.1 of, the Health and Safety Code, and to amend Sections 106 and 10113.95 of, and to repeal Section 12693.365 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1749, as amended, Committee on Health. ~~Committee on Health:~~ Health care coverage.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care.

~~This bill would make technical, nonsubstantive changes to various provisions pertaining to the regulation of health care service plans and would also delete certain obsolete provisions.~~

~~(2) Existing~~

Existing law *also* provides for the regulation of health insurers by the Department of Insurance and defines health insurance as an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits. Under existing law, a health insurer *and a full service health care service plan* that markets and sells individual health insurance policies ~~is~~ *or individual health plan contracts are*

required to maintain underwriting guidelines, as specified, and to file annually with the Insurance Commissioner *or with the Department of Managed Health Care* a general description of ~~its~~ *their* rating and underwriting guidelines for individual health insurance policies *or individual health plan contracts*.

This bill would specify that the requirements applicable to a health insurer *and a full service health care service plan* that markets and sells individual health insurance policies *or individual health plan contracts* apply to a health insurer *or a full service health care service plan* that issues, renews, or amends an individual health insurance policy *or an individual health plan contract. The bill would specify that these requirements do not apply to a closed block of business, as defined, of a plan or health insurer.* The bill would provide that, *in a statute that becomes* effective January 1, 2008, the term "specialized health insurance policy" means a policy of health insurance for covered benefits in a single specialized area of health care. *The bill would make nonsubstantive changes to various provisions pertaining to the regulation of health care service plans and would delete certain obsolete provisions.*

~~(3)~~

(2) Existing law establishes the Healthy Families Program administered by the Managed Risk Medical Insurance Board to provide health care services to eligible children. Existing law authorizes certain geographic managed care plans, as defined, that do not have a commercial license from the Department of Managed Health Care to contract with the board for a maximum period of 12 months.

This bill would repeal that provision.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 1341.4 of the Health and Safety Code is amended to read:

1341.4. (a) In order to effectively support the Department of Managed Health Care in the administration of this law, there is hereby established in the State Treasury, the Managed Care Fund. The administration of the Department of ManagedHealth Care shall be supported from the Managed Care Fund.

(b) In any fiscal year, the Managed Care Fund shall maintain not more than a prudent 5 percent reserve unless otherwise determined by the Department of Finance.

SEC. 2. Section 1342.1 of the Health and Safety Code is repealed.

SEC. 3. Section 1342.5 of the Health and Safety Code is amended to read:

1342.5. The director shall consult with the Insurance Commissioner prior to adopting any regulations applicable to health care service plans subject to this chapter and other entities governed by the Insurance Code for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to these plans and entities by the Insurance Commissioner and the Director of the Department of Managed Health Care.

SEC. 4. Section 1343 of the Health and Safety Code is amended to read:

1343. (a) This chapter shall apply to health care service plans and specialized health care service plan contracts as defined in subdivisions (f) and (o) of Section 1345.

(b) The director may by the adoption of rules or the issuance of orders deemed necessary and appropriate, either unconditionally or upon specified terms and conditions or for specified periods, exempt from this chapter any class of persons or plan contracts if the director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under this chapter, and that the regulation of the persons or plan contracts is not essential to the purposes of this chapter.

(c) The director, upon request of the Director of HealthCare Services, shall exempt from this chapter any county-operated pilot program contracting with the State Department of HealthCare Services pursuant to Article 7 (commencing with Section 14490) of Chapter 8 of Part 3 of Division 9 of the Welfare and Institutions Code. The director may exempt non-county-operated pilot programs upon request of the Director of HealthCare Services. Those exemptions may be subject to conditions the Director of HealthCare Services deems appropriate.

(d) Upon the request of the Director of Mental Health, the director may exempt from this chapter any mental health plan contractor or any capitated rate contract under Part 2.5

(commencing with Section 5775) of Division 5 of the Welfare and Institutions Code. Those exemptions may be subject to conditions the Director of Mental Health deems appropriate.

(e) This chapter shall not apply to:

(1) A person organized and operating pursuant to a certificate issued by the Insurance Commissioner unless the entity is directly providing the health care service through those entity-owned or contracting health facilities and providers, in which case this chapter shall apply to the insurer's plan and to the insurer.

(2) A plan directly operated by a bona fide public or private institution of higher learning which directly provides health care services only to its students, faculty, staff, administration, and their respective dependents.

(3) A person who does all of the following:

(A) Promises to provide care for life or for more than one year in return for a transfer of consideration from, or on behalf of, a person 60 years of age or older.

(B) Has obtained a written license pursuant to Chapter 2 (commencing with Section 1250) or Chapter 3.2 (commencing with Section 1569).

(C) Has obtained a certificate of authority from the State Department of Social Services.

(4) The Major Risk Medical Insurance Board when engaging in activities under Chapter 8 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, Part 6.3 (commencing with Section 12694) of Division 2 of the Insurance Code, and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code.

(5) The California Small Group Reinsurance Fund.

SEC. 5. Section 1347.15 of the Health and Safety Code is amended to read:

1347.15. (a) There is hereby established in the Department of Managed Health Care the Financial Solvency Standards Board composed of eight members. The members shall consist of the director, or the director's designee, and seven members appointed by the director. The seven members appointed by the director may be, but are not necessarily limited to, individuals with training and experience in the following subject areas or fields: medical and health care economics; accountancy, with experience in integrated or affiliated health care delivery systems; excess loss insurance

underwriting in the medical, hospital, and health plan business; actuarial studies in the area of health care delivery systems; management and administration in integrated or affiliated health care delivery systems; investment banking; and information technology in integrated or affiliated health care delivery systems. The members appointed by the director shall be appointed for a term of three years, but may be removed or reappointed by the director before the expiration of the term.

(b) The purpose of the board is to do all of the following:

(1) Advise the director on matters of financial solvency affecting the delivery of health care services.

(2) Develop and recommend to the director financial solvency requirements and standards relating to plan operations, plan-affiliate operations and transactions, plan-provider contractual relationships, and provider-affiliate operations and transactions.

(3) Periodically monitor and report on the implementation and results of the financial solvency requirements and standards.

(c) Financial solvency requirements and standards recommended to the director by the board may, after a period of review and comment not to exceed 45 days, be noticed for adoption as regulations as proposed or modified under the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). During the director's 45-day review and comment period, the director, in consultation with the board, may postpone the adoption of the requirements and standards pending further review and comment. Nothing in this subdivision prohibits the director from adopting regulations, including emergency regulations, under the rulemaking provisions of the Administrative Procedure Act.

(d) The board shall meet at least quarterly and at the call of the chair. In order to preserve the independence of the board, the director shall not serve as chair. The members of the board may establish their own rules and procedures. All members shall serve without compensation, but shall be reimbursed from department funds for expenses actually and necessarily incurred in the performance of their duties.

(e) For purposes of this section, "board" means the Financial Solvency Standards Board.

SEC. 6. Section 1352 of the Health and Safety Code is amended to read:

1352. (a) A licensed plan shall, within 30 days after any change in the information contained in its application, other than financial or statistical information, file an amendment thereto in the manner the director may by rule prescribe setting forth the changed information. However, the addition of any association, partnership, or corporation in a controlling, controlled, or affiliated status relative to the plan shall necessitate filing, within a 30-day period of an authorization for disclosure to the director of financial records of the person pursuant to Section 7473 of the Government Code.

(b) Prior to a material modification of its plan or operations, a plan shall give notice thereof to the director, who shall, within 20 business days or such additional time as the plan may specify, by order approve, disapprove, suspend, or postpone the effectiveness of the change, subject to Section 1354.

(c) A plan shall, within five days, give written notice to the director in the form as by rule may be prescribed, of a change in the officers, directors, partners, controlling shareholders, principal creditors, or persons occupying similar positions or performing similar functions, of the plan and of a management company of the plan, and of a parent company of the plan or management company. The director may by rule define the positions, duties, and relationships which are referred to in this subdivision.

(d) The fee for filing a notice of material modification pursuant to subdivision (b) shall be the actual cost to the director of processing the notice, including overhead, but shall not exceed seven hundred fifty dollars ($750).

SEC. 7. Section 1367.07 of the Health and Safety Code is amended to read:

1367.07. Within one year after a health care service plan's assessment pursuant to subdivision (b) of Section ~~1367.06~~ *1367.04*, the health care service plan shall report to the department, in a format specified by the department, regarding internal policies and procedures related to cultural appropriateness in each of the following contexts:

(a) Collection of data regarding the enrollee population pursuant to the health care service plan's assessment conducted in accordance with subdivision (b) of Section ~~1367.06~~ *1367.04*.

(b) Education of health care service plan staff who have routine contact with enrollees regarding the diverse needs of the enrollee population.

(c) Recruitment and retention efforts that encourage workforce diversity.

(d) Evaluation of the health care service plan's programs and services with respect to the plan's enrollee population, using processes such as an analysis of complaints and satisfaction survey results.

(e) The periodic provision of information regarding the ethnic diversity of the plan's enrollee population and any related strategies to plan providers. Plans may use existing means of communication.

(f) The periodic provision of educational information to plan enrollees on the plan's services and programs. Plans may use existing means of communications.

SEC. 8. Section 1389.4 of the Health and Safety Code is amended to read:

1389.4. (a) A full service health care service plan that ~~markets and sells~~ *issues, renews, or amends* individual health plan contracts shall be subject to this section.

(b) A health care service plan subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the plan makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the plan rating and underwriting criteria comply with Sections 1365.5 and 1389.1 and all other applicable provisions of state and federal law.

(c) On or before June 1, 2006, and annually thereafter, every health care service plan shall file with the department a general description of the criteria, policies, procedures, or guidelines the plan uses for rating and underwriting decisions related to individual health plan contracts, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the plan products for which they would be eligible. A plan may comply with this section by submitting to the department underwriting materials or resource guides provided to

plan solicitors or solicitor firms, provided that those materials include the information required to be submitted by this section.

(d) Commencing September 1, 2006, the director shall post on the department's Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the Major Risk Medical Insurance Program. The director shall develop the information for the Web site in consultation with the Department of Insurance to enhance the consistency of information provided to consumers. Information about individual health coverage shall also include the following notification:

"Please examine your options carefully before declining group coverage or continuation coverage, such as COBRA, that may be available to you. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(e) Nothing in this section shall authorize public disclosure of company specific rating and underwriting criteria and practices submitted to the director.

(f) This section shall not apply to a closed block of business as defined in Section 1367.15.

~~SEC. 7.~~

SEC. 9. Section 106 of the Insurance Code is amended to read:

106. (a) Disability insurance includes insurance appertaining to injury, disablement or death resulting to the insured from accidents, and appertaining to disablements resulting to the insured from sickness.

(b) In statutes that become effective on or after January 1, 2002, the term "health insurance" for purposes of this code shall mean an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits. The term "health insurance" shall not include any of the following kinds of insurance:

(1) Accidental death and accidental death and dismemberment.

(2) Disability insurance, including hospital indemnity, accident only, and specified disease insurance that pays benefits on a fixed benefit, cash payment only basis.

(3) Credit disability, as defined in subdivision (2) of Section 779.2.

(4) Coverage issued as a supplement to liability insurance.

(5) Disability income, as defined in subdivision (i) of Section 799.01.

(6) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) Insurance arising out of a workers' compensation or similar law.

(8) Long-term care.

(c) ~~Effective~~ *In a statute that becomes effective on or after* January 1, 2008, the term "specialized health insurance policy" as used in this code shall mean a policy of health insurance for covered benefits in a single specialized area of health care, *including dental-only, vision-only, and behavioral health-only policies*.

~~SEC. 8.~~

SEC. 10. Section 10113.95 of the Insurance Code is amended to read:

10113.95. (a) A health insurer that issues, renews, or amends individual health insurance policies shall be subject to this section.

(b) An insurer subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the insurer makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the plan rating and underwriting criteria comply with Sections 10140 and 10291.5 and all other applicable provisions.

(c) On or before June 1, 2006, and annually thereafter, every insurer shall file with the commissioner a general description of the criteria, policies, procedures, or guidelines that the insurer uses for rating and underwriting decisions related to individual health insurance policies, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the health insurance products for which they would be eligible. An insurer may comply with this section by submitting

to the department underwriting materials or resource guides provided to agents and brokers, provided that those materials include the information required to be submitted by this section.

(d) Commencing September 1, 2006, the commissioner shall post on the department's Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the Major Risk Medical Insurance Program. The commissioner shall develop the information for the Web site in consultation with the Department of Managed Health Care to enhance the consistency of information provided to consumers. Information about individual health insurance shall also include the following notification:

"Please examine your options carefully before declining group coverage or continuation coverage, such as COBRA, that may be available to you. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(e) Nothing in this section shall authorize public disclosure of company-specific rating and underwriting criteria and practices submitted to the commissioner.

(f) This section shall not apply to a closed block of business as defined in Section 10176.10.

~~SEC. 9.~~

SEC. 11. Section 12693.365 of the Insurance Code is repealed.

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